United States Department of Labor
Employees' Compensation Appeals Board

R.C., Appellant	)	
and	)	**Docket No. 15-1612**
	)	**Issued: March 3, 2016**
DEPARTMENT OF HEALTH & HUMAN SERVICES, FOOD & DRUG ADMINISTRATION, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 21, 2015 appellant filed an appeal of a January 22, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3(e), the Board has jurisdiction over the merits of this case.[2]

ISSUE

The issue is whether appellant has more than a two percent permanent impairment of his right upper extremity and a one percent permanent impairment of his left upper extremity, for which he has received schedule awards.

[1] 5 U.S.C. § 8101 *et seq.*

[2] Appellant timely requested an oral argument before the Board. By order dated November 17, 2015, the Board exercised its discretion and denied the request for oral argument as the issue on appeal could be fully addressed on the record. *Order Denying Request for Oral Argument*, Docket No. 15-1612 (issued November 17, 2015).

FACTUAL HISTORY

Appellant, a 51-year-old investigator, filed a claim for traumatic injury (Form CA-1) on March 22, 2007 alleging that he sustained aggravation of a herniated cervical disc when the bus on which he was a passenger abruptly stopped. OWCP accepted the claim for neck sprain, aggravation of degenerative cervical intervertebral disc, C5-7, and aggravation of cervical spondylosis with myelopathy, C6-7. Appellant returned to work intermittently until he stopped work on March 31, 2008. He retired from federal employment on February 28, 2009.

Appellant underwent a magnetic resonance imaging (MRI) scan of his cervical spine on January 21, 2011. The results of this test showed: degenerative changes of the intervertebral discs with mild posterior C2-3, C3-4, and C7-Tl disc bulges and/or osteophytic spurring; moderate broad-based posterior C5-6 disc protrusion which displaced the spinal cord posteriorly; and mild narrowing of the spinal canal at C6-7.

In a report dated May 20, 2013, Dr. J. Arden Blough, a specialist in family practice, found that appellant had a 14 percent impairment to the right upper extremity and a 14 percent impairment to the left upper extremity based on moderate sensory and moderate motor deficits of the C6 nerve. He advised that on examination of the cervical spine appellant had tenderness to palpation in the bilateral paraspinal musculature from C2 through TI. Dr. Blough noted that appellant's cervical pain radiated into the upper extremities with numbness and tingling, worse on the right side. He reported that appellant showed weakness against resistance as demonstrated in the cervical flexors and extensors. Appellant also had weakness in the bilateral elbows and wrists against resisted flexion and extension. Dr. Blough tested appellant with a Jamar dynamometer, which revealed 72 pounds of force with the right hand and 78 pounds with the left hand.

Dr. Blough found that appellant had a 14 percent permanent impairment to the right upper extremity due to chronic radicular symptoms to his right upper extremity, which caused moderate sensory and moderate motor deficits of the C6 nerve. He calculated his impairment rating for the neck, shoulders, arms, and hands by using *The Guides Newsletter* "Rating Spinal Nerve Extremity Impairment using the sixth edition" (July/August 2009). Dr. Blough relied on Table 1 of the July and August 2009 *The Guides Newsletter*, finding that he had a class 1 impairment for a moderate sensory deficit of the C6 nerve with a mid-range default value of three percent and a class 1, moderate motor deficit of the C6 nerve with a mid-range default value of nine percent, based on his history of injury with continued complaints of pain, neuropathy, and weakness as documented in previous examinations and present at the time of his current examination. He noted that appellant's January 21, 2011 cervical MRI scan showed degenerative changes and C2-3, C3-4, and C7-Tl disc bulges and/or osteophytic spurring, with C5-6 disc protrusion and mild narrowing of the spinal canal at C6-7. Dr. Blough also noted that the result of a February 15, 2011 electromyelogram (EMG) showed findings suggestive of and consistent with mild sensory neuropathy involving the upper extremities, with superimposed mild bilateral median neuropathy of the wrists compatible with mild bilateral carpal tunnel syndrome.[3]

[3] The actual February 15, 2011 EMG report is not included in the instant record.

Applying the net adjustment formula at Section 15.3, pages 406-11 of the American Medical Association, *Guides to the Evaluation Permanent Impairment*, (sixth edition) (A.M.A., *Guides*),[4] Dr. Blough found that the grade modifier at Table 15-7, page 406 for functional history was one, for pain/symptoms with vigorous/strenuous activity, a moderate problem, consistent with appellant's *Quick*Dash score of 59.4. He found that the grade modifier for clinical studies at Table 15-9, page 410 was two. Dr. Blough calculated the net adjusted default impairment of grade E. This yielded a five percent impairment for moderate sensory deficit and a nine percent impairment for moderate motor deficits, in accordance with Table 1 of *The Guides Newsletter*. Relying on the Combined Values Chart at page 604 of the A.M.A., *Guides*, Dr. Blough rated a 14 percent impairment to the right upper extremity due to C6 radiculopathy. He utilized the same methods described above to find that appellant had a 14 percent left upper extremity impairment for C6 radiculopathy.

On November 13, 2013 appellant filed a Form CA-7 claim for schedule award based on a partial loss of use of his right and left upper extremities.

In a March 17, 2014 report, Dr. David D. Zimmerman, a Board certified internist and an OWCP medical adviser, found the ratings of Dr. Blough could not be accepted. He found that the excellent result on the dynamometer precluded the acceptance of weakness in either upper extremity. The weakness rating was based only on subjective findings which were inconsistent with prior examinations. Dr. Zimmerman concluded that these strength deficits might be due to entrapment neuropathy of the right and left upper extremity as shown by EMG/nerve conduction study (NCS) results. He recommended referral to a second opinion examination.

In an April 3, 2014 report, OWCP medical adviser reiterated that appellant's impairment rating could be based on radicular residuals of a cervical spine diagnosis, noting that a recent EMG/NCS was reported to have shown right and left upper extremity peripheral nerve entrapment, weakness and pain.

OWCP referred appellant for a second opinion examination and impairment evaluation with Dr. Kala Danushkodi, Board-certified in physical medicine and rehabilitation. In a May 1, 2014 report, she found that appellant had a six percent permanent impairment of the right upper extremity and a one percent permanent impairment of the left upper extremity. Dr. Danushkodi advised that on examination appellant had normal cervical range of motion, diffuse tenderness of cervical muscles, a positive Spurling sign with radiating pain, full range of shoulder motion, manual muscle strength five over five, altered sensation in C5-6 dermatome and left C7 dermatome, symmetric deep tendon reflexes, normal upper extremity muscle strength, and steady gait. She relied on Table 1 of *The Guides Newsletter*, finding that appellant had a class 1 impairment for a mild sensory deficit of the upper trunk C5-6 nerve with a value of three percent with no motor deficit of the C6 nerve. Applying the net adjustment formula at section 15.3, pages 406-11 of the A.M.A., *Guides*,[5] Dr. Danushkodi found that the grade modifier at Table 15-7, page 406 for functional history was two, for constant symptoms and ability to perform self-care unassisted. She found that the grade modifier for clinical studies at Table 15-9, page 410 was

[4] A.M.A., *Guides* 406-11.

[5] *Id*.

two, based on MRI scan results showing moderate pathology. Dr. Danushkodi calculated the net adjusted default impairment for a total of one which produced a rating of grade E. She found that this yielded a six percent impairment for moderate sensory deficit based on radiculopathy, in accordance with Table 1 of the July and August 2009 *The Guides Newsletter*.

With regard to the left upper extremity, Dr. Danushkodi found that appellant had a class 1 impairment for a mild sensory deficit of the middle trunk C7 nerve, with a default impairment of one percent and no motor deficit of the C7 nerve. She found a grade modifier of two at Table 15-7, page 406 for functional history, for constant symptoms and ability to perform self-care unassisted. Dr. Danushkodi rated a grade modifier of two for clinical studies at Table 15-9, page 410 based on MRI scan results showing moderate pathology. She calculated the net adjusted default impairment for a total of one which produced a rating of grade E. Dr. Danushkodi found that this yielded a one percent upper extremity impairment for moderate sensory deficit based on radiculopathy.

In a May 13, 2014 report, Dr. Zimmerman agreed with Dr. Danushkodi's rating for the left upper extremity, but disagreed with the rating for the right. He noted that, although Dr. Danushkodi selected a mild sensory deficit assigned to class 1, with a default value of three percent, there is not rating in *The Guides Newsletter* that corresponds to three percent. The only option for a C5 mild sensory deficit was from zero to one percent. The only options for C6 mild sensory deficient were from zero to two percent. Giving appellant the higher rating and using Dr. Danushkodi's examination findings, he found a right upper extremity rating of two percent.

By decision dated May 30, 2014, OWCP granted appellant a schedule award for a two percent permanent impairment of the right upper extremity and a one percent impairment of the left upper extremity for the period May 1 to July 5, 2014, for a total of 9.36 weeks of compensation.

On June 27, 2014 appellant requested a review of the record.

In a June 24, 2014 report, received by OWCP on July 1, 2014, Dr. Kenri Honda, a chiropractor, advised that he had treated appellant since September 2008 for his work-related cervical condition and expressed his disagreement with the impairment rating of OWCP medical adviser. He did not provide evidence of subluxation as shown by x-ray evaluation.

By decision dated January 22, 2015, an OWCP hearing representative affirmed the May 30, 2014 decision.

LEGAL PRECEDENT

The schedule award provision of FECA[6] and its implementing regulations[7] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404. Effective May 1, 2009, OWCP began using the A.M.A., *Guides*, (6th ed. 2009). *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013) and *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

loss, or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[8] The claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his employment.[9]

ANALYSIS

OWCP accepted the conditions of neck sprain, aggravation of degenerative cervical intervertebral disc, C5-7, and aggravation of cervical spondylosis with myelopathy, C6-7.

With regard to peripheral nerve impairments and radiculopathy to the upper or lower extremities resulting from spinal injuries, *The Guides Newsletter* is to be applied.[10] Dr. Zimmerman rated a two percent permanent right upper extremity impairment and a one percent permanent left upper extremity impairment for radiculopathy. He properly used Table 1 of *The Guides Newsletter*, finding that appellant had a class 1 impairment which yielded a grade of E for mild sensory deficit at C5-6, which yielded a two percent impairment for the right upper extremity and a one percent impairment for the left upper extremity. The medical adviser based his impairment on peripheral nerve entrapment stemming from the cervical spine, as instructed by OWCP in its April 3, 2014 memorandum. He also based these ratings on the examination findings of Dr. Danushkodi and explained the calculation error made in her rating.

Dr. Blough, appellant's treating physician, rated a 14 percent bilateral upper extremity impairment, but this rating was based on inconsistent examination finds regarding strength deficit. As Dr. Zimmerman's rating was the only rating that properly followed *The Guides Newsletter*, the Board finds that OWCP properly found two percent permanent impairment of the right upper extremity and one percent permanent impairment of the left upper extremity.[11] The Board therefore affirms that appellant has not established more than a two percent permanent right upper extremity and a one percent permanent left upper extremity permanent impairment for radiculopathy.

[8] *Id.*

[9] *Veronica Williams*, 56 ECAB 367, 370 (2005).

[10] *See G.N.*, Docket No. 10-850 (issued November 12, 2010); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1, *supra* note 8.

[11] The report from Dr. Honda does not constitute medical evidence pursuant to section 8101(2) because he did not provide a diagnosis of subluxation based on x-ray results. *See* 5 U.S.C § 8101(2). Section 8101(2) of FECA provides that the term physician includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist and subject to regulations by the Secretary. Without a diagnosis of spinal subluxation from an x-ray, a chiropractor is not considered a physician under FECA and his opinion does not constitute competent medical evidence. *See Jay K. Tomokiyo*, 51 ECAB 361, 367-68 (2000).

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has not established that he has more than a two percent permanent impairment of his right upper extremity and a one percent permanent impairment of his left upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the January 22, 2015 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: March 3, 2016
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board